



State Office of Victim Assistance  
Sexual Assault Protocol (SAP)  
Billing Statement

Name (last, first, MI): \_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: ☐ Male ☐ Female  
Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Name of Healthcare Provider: \_\_\_\_\_ ACC#: \_\_\_\_\_  
Contact Number(\_\_\_\_) \_\_\_\_-\_\_\_\_ Date of Service: (mm/dd/yy) \_\_\_\_/\_\_\_\_/\_\_\_\_

Laboratory Services

- ☐ **Gonorrhea Culture**  
☐ Oral (\$12)  
☐ Rectal (\$12)  
☐ Vaginal (\$12)
- ☐ **Chlamydia Culture**  
☐ Oral (\$35)  
☐ Rectal (\$35)  
☐ Vaginal (\$35)
- ☐ NAAT (\$50)  
☐ Herpes Culture (\$20)  
☐ Vaginal Culture (\$20)  
☐ Wet Prep/KOH Prep (\$10)  
☐ Serum Pregnancy Test (\$25)

- ☐ **Gram Stain**  
☐ Urethral (\$10)  
☐ Rectal (\$10)  
☐ Vaginal (\$10)
- ☐ RPR, VDRL, Syphilis (\$10)  
☐ Presence of motile sperm (\$5)  
☐ Hepatitis B (\$40)  
☐ HIV HTLVI (\$20)  
☐ Urinalysis (\$18)  
☐ Blood Drawing Fee (\$5)  
☐ Urine Culture (\$20)  
☐ Urine Pregnancy Test (\$20)

Medical Services

- ☐ Physician, FNP, NP Fee (\$105)  
☐ Emergency Room Fee (\$75)  
☐ SANE Fee (\$80)  
☐ Colposcopy Fee (\$90)  
☐ Clinic Fee (\$50)  
☐ Supplies (\$12)

Medications

Medication	fee	Qty	Medication	fee	Qty	Total Amount Billed  \$ _____
<input type="checkbox"/> Rocephin (Ceftriaxone) (injection)	\$85 ea		<input type="checkbox"/> Plan B Levonorgestrel	\$25 ea		
<input type="checkbox"/> Flagyl (Metronidazole) (tabs/ea)	\$3 ea		<input type="checkbox"/> Ovral (Norgestrel) (tabs/each)	\$1.75 ea		
<input type="checkbox"/> Phenergen (Promethazine) (tabs/ea)	\$2.20 ea		<input type="checkbox"/> Zithromax (Azithromycin) (tabs/ea)	\$10 ea		
<input type="checkbox"/> Phenergen (suppository 50mg ea)	\$12.74 ea		<input type="checkbox"/> Lidocaine	\$21 ea		
<input type="checkbox"/> Suprax (Cefixime) (tabs/ea)	\$11.25 ea		<input type="checkbox"/> Tetanus	\$21 ea		
<input type="checkbox"/> Cipro (Ciprofloxacin) (tabs/ea)	\$8.00 ea		<input type="checkbox"/> Other (specify) _____			
<input type="checkbox"/> Doxycycline (tabs/ea)	\$2.64 ea					
<input type="checkbox"/> Hepatitis B vaccine	\$21.00 ea					

Please Remit Payment To:

Fed Tax# \_\_\_\_\_

Health Care Provider must attach a copy of the **Medical Examination Release Form (located in the SLED approved protocol kit)** to this **Protocol Billing Statement** for payment and forward to:

State Office of Victim Assistance  
1205 Pendleton Street  
Edgar A. Brown Building, Room 401  
Columbia, SC 29201